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| A guide for out-of-home carers  Client incident management system (CIMS) |
| January 2020 |

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# Introduction

The great majority of children and young people in out-of-home care receive high-quality care from dedicated carers who have made a commitment to making a difference in the lives of these children and young people. From time to time, allegations may be raised about carers by the child or young person they are caring for, the child or young person’s family, or members of the community.

All children and young people in out-of-home care have come from a history of abuse or trauma. This history can heavily influence their behaviour and their trust and view of adults and the world. Therefore, it is not surprising that carers, like teachers and others who are placed in a position of trust with children and young people, are especially vulnerable to complaints and allegations at some time during their involvement in the out-of-home care system.

As the safety and wellbeing of children and young people in out-of-home care is paramount, every concern must be taken seriously by the Department of Health and Human Services (the department), department-funded out-of-home care providers (service providers) and carers, and thoroughly explored to ensure the safety of the child or young person.

When an allegation is raised, it can be unsettling and stressful for a carer. It is important that processes are in place that, while ensuring the safety of the child or young person, also ensure that carers are treated in a fair and just manner and are informed and supported throughout the process.

The client incident management system (CIMS) was implemented on 15 January 2018 for all in-scope service providers. CIMS focuses on the safety and wellbeing of clients and outlines what needs to happen when an incident occurs that alleges abuse, unexplained injury or poor-quality care that has a direct impact on a child or young person in out-of-home care.

The Client incident management guide describes each of the actions and responsibilities of the service providers and the department during the management of a client incident. The Client incident management guide addendum: Out-of-home care (Out-of-home care addendum) provides specific guidance to support the policies and procedures outlined in the Client incident management guide for allegations of abuse by carers of children living in out-of-home care. The Client incident management guide and Out-of-home care addendum replace the Guidelines for responding to quality of care concerns in out-of-home care.

This carer guide summarises some of the key information contained in the Client incident management guide and the Out-of-home care addendum that is specifically relevant to out-of-home carers.

Carers are encouraged to discuss any queries regarding the information in this document with their caseworker.

# CIMS aims, objectives and principles

The overarching **aim** of CIMS is to support the safety and wellbeing of clients.

The **objectives** of CIMS are to:

* ensure that timely and effective responses to client incidents address client safety and wellbeing
* ensure effective and appropriate investigation of client incidents
* ensure effective and appropriate review of client incidents
* learn from individual incidents and patterns of client incidents, to reduce the risk of harm to clients, and improve the quality of services and the service system
* ensure the accountability of service providers to clients
  + protect and maintain the personal and sensitive information of clients, service provider staff, carers and others from whom a service provider collects personal information for the purpose of client incident reporting.

The following principles underpin the design of CIMS, and guide all actions undertaken:

* **Client-centred** – management of a client incident is respectful of and responsive to a client’s preferences, needs and values while supporting the client’s safety and wellbeing.
* **Outcome-focused** – management of a client incident should enhance a client’s safety and wellbeing first and foremost.
* **Clear, simple and consistent** – CIMS is easily understood and accessible to all stakeholders across the service system, and applies consistently to all service providers.
* **Accountable** – service providers have primary accountability for managing the response to client incidents. Each party involved in the management of a client incident understands their role and responsibilities and will be accountable for decisions or actions taken in regard to an incident.
* **Continually improving** – CIMS facilitates the ongoing identification of issues and implementation of changes that result in better outcomes for client safety and wellbeing.
* **Fit for purpose** – CIMS is capable of meeting the objectives of the system.
  + **Proportionate** – the nature of any investigation, review or other actions following a client incident will be proportionate to the harm caused to the client and the risk of future harm to the client.

# Principles for out-of-home care

In addition to CIMS principles, there are ways of working that are intended to promote and support the effective management of incidents that specifically impact children and young people in out-of-home care, their families and their carers. These are listed below.

**The best interests of the child or young person will always be paramount**

In making decisions, consideration must be given to protecting the child or young person from harm, protecting the child or young person’s rights, promoting their development in age-appropriate ways and facilitating connection to the appropriate supports for them to maintain their cultural identity and links to their community.

Responses to out-of-home care client incidents must be managed in a way that minimises the trauma to the child or young person in care.

**Children and young people should be listened to and heard**

Children and young people should be:

* supported, in a child-friendly way, to tell their story and express any concerns
* provided with ongoing support during, and after, any incident investigation or incident review process
* provided with information in a child-friendly and age-appropriate manner about their rights, the support available to them and the procedures and processes of the incident investigation or incident review that affects them
  + informed of the outcome of an incident investigation or incident review process that affects them in a child-friendly and age-appropriate manner.

**Carers should be treated fairly, honestly and with respect**

Carers should be:

* treated fairly, honestly and with respect
* listened to and heard
* supported through the incident investigation or incident review process and given as much information as is possible without interfering with the process
* given information about the incident investigation or incident review process, the timeframes and what support is available to them
* informed of the outcome of an incident investigation about their alleged conduct and the implications for them
  + informed about complaints and review procedures and processes.

**Collaboration**

Child protection and service providers should work together in a spirit of partnership, collaboration and cooperation to ensure that any actions taken are in the child or young person’s best interests, while maintaining their statutory responsibilities.

**Communication and timeliness**

Incident investigation and decision-making should be well-informed, clearly communicated and timely. These characteristics are consistent with the expectations of effective management of incidents for children and young people in out-of-home care, their families and the carers who are caring for them.

# CIMS

The effective management of a client incident has five stages, as outlined below.

## Figure Overview of CIMS stages

A flow chart of the five CIMS stages:
1. Identification and response
2. Reporting
3. Incident investigation
4. Incident review
(Stage 3 or 4 is required for major impact incidents)
5. Analysis and learning.

CIMS is designed to focus on the impact to the individual client but also to make sure that the process of responding to and managing the incident is appropriate and complete. This means that it is not sufficient to just report an incident that has impacted a child or young person in out-of-home care, but that there is a prescribed process for responding to, managing and learning from incidents to make sure that the chance of any further harm to the children and young people in out-of-home care is reduced.



## 4.2 Definitions of each of the five stages

**4.2.1 Identification and response**

The **identification** of an incident is when an incident that has impacted a client is seen by, or disclosed to, a service provider.

The **response** to an incident is the actions that are taken immediately after an incident to make sure all those involved, and particularly the client, are safe and supported and that any evidence is preserved, where this is needed.

**4.2.2 Reporting**

An electronic incident report, outlining the details of an incident, is provided to the department by the service provider. **The incident report helps service providers and the department know that appropriate actions have been taken or planned to support the client and manage the initial impact of the incident.**

Sometimes, children and young people in out-of-home care may only feel safe to disclose allegations about a carer once they have left their care. It is possible a child or young person in out-of-home care may disclose to a carer an allegation that they were abused, neglected or given poor-quality care by a carer with whom they were previously placed.

If a historical allegation is disclosed to a carer or made about a carer, the carer can expect that this will be managed in the same way as any current client incident in accordance with the Client incident management guide and the Out-of-home care addendum. The only difference is that the initial response to the client might be different as they may no longer be in the care of the person they have made an allegation about and may not be in imminent danger of harm.

The reporting organisation will also consider whether a report to Victoria Police is appropriate for a historical disclosure that alleges or suspects criminal conduct.

**4.2.3 Incident investigation**

**Incident investigations are only undertaken for incidents assessed as having a major impact on a client.** An incident investigation is a formal process of collecting information to find out the facts about an incident. The purpose of an incident investigation is to find out whether there has been abuse or neglect of a client by a staff member, carer or another client. An incident investigation is one option available in response to a major impact client incident.

If an allegation of abuse or neglect, unexplained injury or poor-quality care of a child or young person in out-of-home care is made, screening for an incident investigation will occur.

**4.2.4 Incident review**

**Incident reviews are only undertaken for incidents assessed as having a major impact on a client and as not meeting the threshold for an incident investigation.** An incident review is a process to find out what happened, what was the likely cause of the incident, and whether the incident was managed appropriately. An incident review is also used to identify what can be learnt to reduce the risk of future harm and inform continuous improvement. Unlike an incident investigation, the focus of an incident review is on systems rather than the conduct of specific individuals. There are two types of incident reviews: case reviews and root cause analysis (RCA) reviews.

**4.2.5 Analysis and learning**

An important part of client incident management is to look at the client incident information to consider what can be learned and what can be change to enhance the quality of service and support to clients. The department and service providers will collect and analyse the data to make sure they pick up any emerging trends, identify potential policy changes and mitigate risks.

For more information on the five steps of CIMS, please see the Client incident management guide, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

# Scope of CIMS in out-of-home care

All funded out-of-home care organisations are in scope for CIMS. A service provider is the out-of-home care service that a carer is registered, employed, approved or engaged by. The Client incident management guide applies for the following types of out-of-home care:

* **Home-based care – kinship care** – where relatives or members of a child or young person’s social network are approved to provide accommodation and care for children or young people who require out-of-home care due to abuse or neglect.
* **Home-based care – foster care** – placements for children and young people unable to live with their families due to issues of abuse or neglect. Approved volunteer carers look after children and young people in their own home.
* **Residential care** – out-of-home care provided by employed staff in a residential facility for children and young people where it has been determined by the department that living at home is not consistent with their best interests, due to the risk of abuse and neglect. Residential care includes secure welfare services.
  + **Lead tenant** – the provision of semi-independent accommodation and support for young people   
    15–18 years of age who are unable to live with their family due to issues of abuse or neglect and are in transition to independent living. A volunteer lead tenant lives with a small group of young people and provides them with support and guidance in developing their independent living skills.

Children or young people in placements awaiting finalisation of a permanent care order are also considered to be within the scope of home-based care (foster care or kinship care).

# What is a client incident?



An incident is an event or circumstance that has occurred during service delivery and has a direct impact on a child or young person in out-of-home care.

In CIMS, an incident is assessed as having either a **major** impact or a **non-major** impact on a child or young person. If a carer has known or cared for a number of children and young people in out-of-home care, they will know that sometimes, the same incident can impact children and young people differently. There is no formula to estimate how much of an impact an incident will have on a client, so CIMS is designed to make sure the focus is on an assessment of the impact an incident has on each individual child or young person, taking into account their:

* age
* stage of development
* social background (social skills)
* social isolation (many children in out-of-home care have limited family or community connections)
* motor skills (strength and improved fine motor skills)
* emotional maturity (in understanding and managing emotional states)
* gender (development of a gender identity)
* cognitive ability (mental abilities)
* language (English as an additional language)
* cultural background
  + Aboriginal status.

For more information, please see section 1.3 of the Out-of-home care addendum, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

To make a decision regarding the appropriate categorisation of a client incident, service providers must assess the level of impact the incident has had on each client involved.

There are two categories of client incident – major impact and non-major impact.

**Major impact incidents**

A major impact incident includes:

* the unanticipated death of a client
* severe physical, emotional or psychological injury or suffering that is likely to cause ongoing trauma
  + a pattern of incidents related to one client that, when taken together, meet the level of harm to a client defined above. This may be the case even if each individual incident is a non-major impact incident.

It is important to know that all major impact incidents will be followed by either an incident investigation or an incident review to make sure the appropriate response and learning takes place to keep children and young people in out-of-home care safe from harm.

Both major and non-major impact incidents must be reported to the department within three business days of the incident occurring or being disclosed.

**Non-major impact incidents**

A non-major impact incident includes:

* incidents that cause physical, emotional or psychological injury or suffering, without resulting in ‘major impact’ as defined above
* impacts to the client that do not require significant changes to care requirements, other than short-term interventions (for example, first aid, observation, talking interventions or short-term medical treatment)
* incidents that involve a client but result in minimal harm
  + incidents that do not otherwise meet the criteria for ‘major impact’ above.

Whether an incident has a major or a non-major impact on a child or young person, it is important that carers, service providers and the department work collaboratively to keep children and young people safe and well.

For more information on major and non-major impact incidents, please see section 3.3 of the Client incident management guide, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

# Overview of roles and responsibilities in CIMS

## The role of carers

Carers are crucial to a child or young person’s care team. A care team refers to the group of people tasked with supporting the child or young person in out-of-home care with their best interests in mind at all times. If a carer has any reason to believe that an incident has had a direct impact on a child or young person in their care, they should contact the caseworker at their service provider to advise them of what has happened.

The role of the carer will vary depending on the nature of the client incident. The carer may be the person the child or young person tells about an incident or they may be informed of the incident by another person. Either way, a carer may be asked to provide any relevant information and assist in supporting the child or young person in their care.

## The role of the service provider

The management of client incidents is primarily the responsibility of the service providers. In most cases, the department will only play an oversight role to ensure that incident investigations and incident reviews meet the standards of the Client incident management guide.

This means that the service providers will lead the incident investigation or incident review process and are responsible for informing and supporting carers through all CIMS processes.

## The role of child protection

While it is the primary responsibility of service providers to manage client incidents, child protection still has legal responsibility for case planning and placement decisions for children and young people in out-of-home care. For this reason, service providers will be consulting with child protection throughout the client incident management process and sharing information with them. Child protection will be provided with a copy of Part C of a Carer development plan to assess the ongoing appropriateness of the placement.

For more information on the role of child protection, please see section 3 of the Out-of-home care addendum, which can be found on the CIMS webpage at <http://providers.dhhs.vic.gov.au/cims>.

For more information on the overview of roles and responsibilities in CIMS and out-of-home care, please see section 2 of the Out-of-home care addendum, which can be found on the CIMS webpage at <http://providers.dhhs.vic.gov.au/cims>.

# Investigation of a client incident

## Investigation overview

Service providers are required to ensure the immediate safety, health and wellbeing of the client, carer and other involved parties, obtain medical attention, notify Victoria Police and other emergency services as appropriate, preserve evidence, access specialist victim and support services as required, and contact the carer’s nominated key support person.

**Where a major impact incident alleges abuse, unexplained injury or poor-quality care, the incident will automatically to an incident investigation.**

This investigation will be the primary responsibility of the service provider. The service provider will determine what level of independence is appropriate for each incident investigation, noting that the department still provides oversight to ensure the action recommended is appropriate. If the alleged incident involves the abuse or neglect of a client by a staff member, some degree of independence will usually be required, such as an investigation by a separate business unit or an external organisation.

In exceptional circumstances, the department may jointly manage an incident investigation with the service provider.

**If an incident investigation occurs, the service provider has 28 business days to complete their investigation report and response plan and submit them to the department for endorsement.** There are times when multiple investigations may run on different timeframes and require that an incident investigation is put on hold or extended (for example, if Victoria Police has requested that no action be taken until the police investigation is complete). If this happens, the carer should be advised of this and continue to be supported and informed of the progress of the incident investigation.

### Figure 2: Overview of the incident investigation process



| Tips for carers |
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| Where the incident does not relate to your conduct, you may be asked to provide any relevant information and assist in supporting the child or young person in your care.  Where the allegation is about your conduct, you should be informed of the allegation(s) about you as soon as the situation allows and invited to participate in any incident investigation that occurs about your alleged conduct. |

1. **Full investigation (internal)**

In some cases, the service provider will have the capability to undertake an investigation that meets the minimum standards set out in the next section, in such a way that does not compromise the independence of the investigation. This may not be possible in smaller organisations without separate business units or an independent investigative function.

1. **Full investigation (external)**

In other cases, the service provider will need to commission an investigation by an external party to ensure the investigation is robust, objective and expert. The service provider may commission an investigator, or a person from another organisation with relevant expertise.

1. **Investigation outcome and root cause analysis**

In instances where the information and evidence available (such as CCTV footage) enable a conclusion to be reached during the initial follow-up and assessment as to whether allegations can (or cannot) be substantiated, service providers can complete an **investigation outcome and case review report** or an **investigation outcome and root cause analysis report** to advise the department of:

* 1. the investigation outcome (substantiated or not substantiated), on the balance of probabilities
  2. the rationale for not further investigating
  3. the evidence that supports that outcome
  4. the approach and findings of the subsequent review.

Where an incident relates to potential staff-to-client abuse or poor quality of care, some degree of independence is required for the investigation. The service provider must consider how the independence requirement can be met in a given case. Depending on the nature of the incident and the organisation, one of the following may be appropriate to conduct the investigation:

* an area of the organisation that is sufficiently independent from staff who are the subject of any allegations, such as another division or an independent investigative function
* another service provider independent from the staff who are the subject of any allegations
* an external investigative body.

| Tips for carers |
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| You will be advised of the allegations and given information about the process to be undertaken (the timing of this will depend on the nature of the allegation; for example, an allegation of a criminal nature has to be reported to police).  The alleged incident will be assessed via the screening for investigation process to determine what action is to be taken. You will be advised of the outcome of the screening for investigation process once the situation allows.  Where the alleged incident is of a criminal nature (such as alleged sexual abuse), Victoria Police will be notified prior to you being contacted.  If an incident is related to an Aboriginal child or young person in your care, the relevant Aboriginal Child Specialist Advice and Support Service (ACSASS) will be informed and consulted, as will the local Aboriginal community-controlled organisation or a respected community member where appropriate.  The outcome of the screening process of the alleged incident will be documented and filed on both your service provider file and the child or young person’s case file. |

For more information on screening for incident investigations, please see section 4.2 of the Client incident management guide, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

## Incident investigation timeframes and expectations

**If an incident investigation is to be undertaken, it must be completed within 28 business days of the department endorsing the major impact incident.** This timeframe excludes any time that the incident investigation is put on hold by Victoria Police.

Any incident investigation must comply with the following minimum standards:

* Each incident investigation will begin with an overall planning process and result in a written investigation report.
* The incident investigation will adopt a person-centred and rights-based approach, taking into account what is important to the child or young person.
* The incident investigation will remain impartial and independent at all times.
* The incident investigation should abide by the standard principles of good investigations.
  + The incident investigation report will be provided to the department for review and endorsement.

**If an incident investigation occurs in relation to allegations made about a carer, the carer will be offered the opportunity to have their say at interview.** If the carer chooses to participate in the interview about the allegations, they can expect that they will be advised of:

* the purpose of the interview
* the role of the people conducting the interview
* their right to have a support person present at the interview
* the nature of the allegation
* how the interview will be recorded and that a copy of the interview record will be given to them
* how the information collected may be requested by another child and young person safeguarding body (such as the Commission for Children and Young People [CCYP] for the requirements of the Reportable Conduct Scheme, explained in section 10.2)
* the expected incident investigation procedures and timeframes
* who will be their liaison person to provide ongoing information and updates to them, including the outcome of the investigation
* support services available to them
* placement arrangements for any children or young people in their care during the incident investigation, including details of their reimbursement or salary arrangements where applicable
  + how to seek a review, resolve disputes or make a complaint.

| Tips for carers |
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| Sometimes it is hard to remember all the information discussed during an investigation interview, so it is reasonable to have a support person attend an interview with you if you wish.  Your support person could be your caseworker or, if you are a foster carer, someone from the Foster Care Association of Victoria. It is important that your support person is not involved in the alleged incident that is being investigated.  You can choose what level of participation you have in an incident investigation regarding an allegation. However, it is important to understand that the incident investigation will occur whether or not you choose to respond to the allegation. You are encouraged to take the opportunity to have your say throughout the process.  It is reasonable that you ask questions and request that you are given a copy of the carer development plan if it hasn’t already been provided to you. This way you can make sure you are clear about exactly what actions are required of you, the timeframe, how your progress will be monitored and by whom. This will also allow you to be sure that your input into the carer development plan has been represented accurately.  The nature of the allegation about you will influence the timing of when you are advised of the allegation. For example, if the police are involved, you may not be notified straight away. However, in other cases, your service provider should advise you of the allegation as soon as the situation allows.  Once you are advised of an allegation made about you, you can ask that the allegation also be provided to you in writing so you can be clear about what is being considered for the incident investigation.  If the allegations are considered to be unfounded, the screening outcome will provide a record of this, protecting you against any unfounded innuendo and false allegations |

For information on the principles of good investigations, please see section 2 of the Investigative framework, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

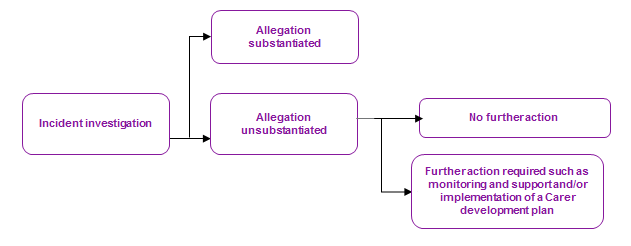
### Standard of proof for incident investigations

The civil standard of proof, which is ‘the balance of probabilities’, applies to incident investigations. This means that the evidence is weighed up and a decision is made as to what is most likely to have occurred. In order to reach an outcome that the abuse is substantiated, an investigator must be satisfied that the evidence shows that it is more than likely than not that abuse has occurred. If this happens, the incident investigation report must outline the evidence and rationale that supports the investigator’s substantiation decision.

## Incident investigation outcomes

The outcomes of an incident investigation into allegations of abuse, unexplained injury or poor-quality care are either substantiated or unsubstantiated.

### Figure 3: Overview of incident investigation outcomes



**Outcome – unsubstantiated**

If the alleged abuse is **unsubstantiated**, the investigator has determined that on the balance of probabilities, abuse is unlikely to have occurred. If the alleged abuse is unsubstantiated, there are two possible additional outcomes:

* **No further action will be taken** and the rationale for this will be recorded on both the carer’s and the child or young person’s file.
  + **Further action is required.** An example of when this might occur is where there is insufficient evidence to substantiate abuse but there is a need for monitoring and support to address any concerns that have been identified. This may be formalised by using a carer development plan.

If the information unearthed during the incident investigation indicates that there are either systemic issues or causal factors within the service provider that still need to be addressed to reduce the chance of any similar or related incidents occurring again, a decision may be made to commence an incident review.

**Outcome – substantiated**

If abuse is **substantiated**, the investigator has determined that on the balance of probabilities, abuse or neglect is likely to have occurred. The type of abuse substantiated will be one or more of the following:

* substantiated – physical abuse
* substantiated – sexual abuse
* substantiated – emotional/psychological abuse
* substantiated – neglect
  + substantiated – financial abuse.

**When the department endorses an incident investigation report that substantiates abuse, decisions need to be made about whether the child or young person, or any other child or young person, should remain in the care of the carer and whether it is appropriate for the carer to continue in their role. While it is the service provider’s responsibility to lead the incident investigation, child protection still retains the case planning and placement decisions for children and young people in out-of-home care as part of its statutory responsibilities.**

If an incident is related to an Aboriginal child or young person in out-of-home care, the relevant ACSASS will be informed and consulted.

Where abuse or neglect has been substantiated, there is a strong basis for considering that continuing in the existing care arrangement is not in the child or young person’s best interests. This decision should, however, be made on a case-by-case basis allowing for the particular circumstances to be appropriately considered. The placement history, relationship with the carer, nature of abuse and degree to which the circumstances surrounding the abuse or neglect constitute an exceptional set of events may all need to be considered. If the caring arrangement is to continue, it will be essential that there is very clear evidence that there is no risk to the safety, stability and development of the child or young person or any other child or young person in the care of the carer.

Where abuse is substantiated against a person other than the carer (for example, the carer’s family members or friends), arrangements must be made that will ensure there is no longer a risk of harm to the child in the placement. If this cannot be arranged then the carer will not be able to continue to provide out-of-home care.

| Tips for carers |
| --- |
| Be aware that it is common to be upset and frustrated throughout the incident investigation process and that you should be supported and informed during the investigation into your alleged conduct. Confirm with your caseworker who your liaison person is for the incident investigation process and how you can contact them should the need arise.  Keep a record of any contact made regarding the allegations about you, including who made the contact, what the allegation was and any interview details. This may be useful to have if you need to re-contact someone for further information or clarification. In Appendix 1 there is a record sheet for carers, which you can use to help you keep track of the relevant dates and information regarding the allegations.  Remember that it’s in your best interests to record and file details of any investigation processes undertaken regarding your alleged conduct, including those where abuse is not substantiated. That way, if any query is raised in the future, there is clear documentation around the matter being considered and finalised. Decisions need to be made about whether the child or young person, or any other child or young person, should remain in the care of the carer and whether it is appropriate for the carer to continue in their role. |

For more information on incident investigations, please see section 4 of the Client incident management guide, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

For more detailed information about practice considerations when incident investigations are conducted, please see section 2 of the Investigative framework, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

## Police investigations

When an incident involves an allegation of criminal conduct such as physical or sexual assault, the matter must be reported to Victoria Police. The police will determine whether a criminal investigation will occur. A police investigation and an incident investigation may occur at the same time, but usually the police will ask for the service provider’s incident investigation to be put on hold until the police investigation is complete.

**Where the police decide that an investigation is warranted, they will interview the carer as soon as possible after all relevant evidence is obtained. The police will endeavour to conduct an investigation in a timely manner, taking into account the safety and wellbeing of the child and the carer’s rights. However, some police investigations may be lengthy due to the complexity of gathering evidence for a criminal investigation.**

To ensure that a criminal investigation is not jeopardised, the service provider that the carer is employed, approved or engaged by will liaise with police regarding what information can be shared with the carer, the service provider and the child or young person and their family.

It is important to know that the decision to lay criminal charges is determined by the police; however, an incident investigation outcome can substantiate abuse even when the police decide not to lay criminal charges.

# Incident reviews

## Overview of incident reviews

The Client incident management guide specifies that all major impact incidents that do not meet the threshold for an incident investigation must be followed up with an incident review.

Incident reviews are distinguished from incident investigations because they do not focus on determining whether there has been abuse of a child or young person by a staff member, carer or another client.

Incident reviews focus on an analysis of what happened to determine whether an incident was managed appropriately and to identify any incident causes that can be learnt from to reduce the risk of any future harm.

There are two types of incident reviews that can occur under the Client incident management guide: a case review and an RCA review.

### Case review

A case review is designed to identify what happened in a client incident, and any process or system issues that might have contributed to the occurrence of the incident.

A case review must be completed within 21 business days of the incident report being endorsed by the department.

A case review is less structured and resource-intensive than an RCA review.

A service provider’s chief executive officer or delegated authority must approve the case review report and action plan. A case review does not need to be submitted to the department, but it may be requested on an ad-hoc basis.

### RCA review

An RCA review is a structured review for identifying the causal factor(s) that underlie a client incident, in order to facilitate learning from that incident. In contrast to a case review, an RCA review is more structured and resource-intensive. It will only be required in a small number of cases – those involving the most serious and complex incidents.

An RCA review report and risk reduction action plan must be submitted to the department within 60 business days of the department endorsing the incident report.

## Summary of the incident review process

### Figure 4: The incident review process









**The process followed by any incident review is to gather information, such as documentary evidence, in order to assess and analyse that information to make findings as to whether the management of an incident was handled appropriately and to identify any learnings to apply in practice.** Carers may be interviewed as a part of the information-gathering process to help ascertain what happened, but an incident review will not be about a carer’s alleged conduct.

It is the role of the service provider to lead and undertake the incident review.

It is common for an incident review to use the findings to make recommendations as to what can be done or changed to reduce the chance of the same incident happening again.

9.3 Role of a carer in incident reviews

It is rare that a carer would be advised of, or asked to participate in, an incident review, as the focus of the review will not be about a carer’s alleged conduct, but rather about service system issues and causal factors that might have put a child or young person in out-of-home care at risk of harm. However, there are some occasions when a carer may be asked to participate in an incident review. These occasions could include:

* a carer reporting an incident that has impacted a child or young person in their care that they believe occurred as a result of a systemic issue within an organisation
* a carer being a support person for a child or young person in their care who may be interviewed as a part of an incident review to help in gathering the information needed to find out why the incident happened and what can be done to reduce the chance of similar or related incidents happening again
  + a carer being interviewed as part of an incident review to help in gathering the information needed to find out why the incident happened and what can be done to reduce the chance of similar or related incidents happening again.

For more information on incident reviews, please see section 5 of the Client incident management guide, which can be found on the [CIMS webpage](http://providers.dhhs.vic.gov.au/cims) at <http://providers.dhhs.vic.gov.au/cims>.

# Data analysis

Incident data analysis includes the monitoring, interrogating and acting on trends identified through the analysis of incident information. The purpose of analysing incident data is to learn from patterns of client incidents in order to safeguard the safety and wellbeing of individual clients, as well as improve the quality of services and the service system.



## 10.1 Role of a carer in data analysis

A carer will never be asked to analyse data related to incidents that have impacted a child or young person in their care. However, sometimes data will alert an organisation to a pattern or escalation of incidents for a child or young person in the care of a particular carer, and in these instances, that carer may be asked to assist in the implementation of a new or adjusted case management plan for the child or young person.

# The legislative context

There are a number of ways that children and young people are safeguarded in out-of-home care. These safeguards include legislation that the department, service providers and carers are required to comply with, as well as oversight bodies and clear standards of safety and support that children and young people can expect from the people who are involved in their care.

This section of the carer guide highlights the legislation, oversight bodies and standards that carers should be aware of in their role as carers of children and young people in out-of-home care. The Client incident management guide and the Out-of-home care addendum do not replace legislative requirements and relevant obligations to report client incidents to other safeguarding bodies.



## 11.1 Children, Youth and Families Act 2005

The Children, Youth and Families Act 2005 (the CYFA) came into effect in Victoria in April 2007.

The CYFA highlights that the best interests of the child and young person are paramount. In determining whether a decision or action is in the best interests of the child or young person, the department, service providers and other relevant bodies must take into account the principles outlined in section 10 of the CYFA, including:

* the need to protect the child or young person from harm
* protection of the child or young person’s rights
  + promotion of the child or young person’s development.

The best interests principles in the CYFA require a focus on children and young people’s safety, stability and development, in the context of their age and stage of life and their culture and gender. These principles support a broader goal for all children and young people: that every child or young person can thrive, learn and grow and be respected and valued to become an effective adult. All decisions about children and young people must consider the best interests principles.

Section 18 of the CYFA enables the Secretary of the Department of Health and Human Services to authorise the principal officer of an Aboriginal agency to assume responsibility for the welfare of a child subject to a Children’s Court protection order.

### 11.1.1 Registration of carers

The CYFA introduced a register of carers who have been approved to care for children and young people in out-of-home care.

The following types of carers must be registered:

* foster carers
* residential carers (including secure welfare) – all staff including permanent, part-time, casual and temporary agency staff
  + providers of services to children at an out-of-home care residence managed by the out-of-home care service.

Kinship carers and permanent carers are **not** in scope for the Carer Register. However, it’s important to know that kinship carers are in scope for the Client incident management guide, as are permanent carers prior to the finalisation of the permanent care order.

The department keeps this confidential register of carers, which records details such as the date of a carer’s approval and the name of the organisation(s) they have been accredited by. The carer’s accrediting organisation arranges the carer registration process for each carer.

During a carer’s assessment and approval/accreditation process, a check of the register is made to be sure they have not previously been disqualified from caring for children or young people in Victoria. People who are not registered or who are currently disqualified from caring cannot be carers.

### 11.1.2 Service provider resolution of disputes

The registration standards for community service organisations require service providers to have written procedures for the resolution of disputes or complaints by staff, carers, children, young people and families. These procedures should include the process for lodging and managing complaints, steps and timeframes in assessing and resolving disputes, and the process to appeal decisions that are made (for example, where a carer disagrees with a decision or recommendation made during the incident investigation).

If a carer disagrees with a decision of an incident investigation to substantiate abuse, they can make a written request for a review of the decision to the chief executive office or delegated authority of the service provider they are employed, approved or engaged by. This written request for a review of a decision must be submitted within 14 business days of parties being notified of the decision. The service provider must send a return letter advising that they have received the carer’s request for a review. The service provider then has 28 business days from when the carer’s written request was received to complete the review of the decision.

Carers are encouraged to contact their nominated contact person at their service provider should they require additional information about the process of seeking a review of a decision or recommendation about them.

For further information, please see the [department’s provider website](https://providers.dhhs.vic.gov.au/registration-out-home-carers) at <https://providers.dhhs.vic.gov.au/registration-out-home-carers>.

### 11.1.3 Independent investigation and Suitability Panel process

The CYFA requires that a registered out-of-home care service must report any allegation of physical or sexual abuse of a child or young person in out-of-home care by a registered foster or residential carer to the Secretary of the department to be considered for independent investigation. This is done via a section 81 report. A section 82 report can also be made by anyone in the community who believes that a registered out-of-home carer has physically or sexually abused a child in his or her care. A section 81 or section 82 report of alleged physical or sexual abuse may be made in addition to a client incident report.

The section 81 or section 82 report will trigger the department to make a decision on whether the allegation should be referred for an independent investigation by an authorised investigator. This type of investigation is different to incident investigations in CIMS, as it is required by legislation, is only related to allegations of physical and sexual abuse for certain types of carers, and must be conducted by an authorised investigator external to the department. These independent investigations may occur in parallel to CIMS. If the authorised investigator finds that, on the balance of probabilities, the abuse is likely to have occurred, the department will make a decision on whether the matter should be referred to the Suitability Panel for its consideration.

As well as introducing a register of carers, the CYFA also established an independent panel called the Suitability Panel. The Suitability Panel is made up of people appointed by government and independent of the department, with a range of qualifications and experience. Referrals to the Suitability Panel can only occur after an authorised investigator investigates and reports back their findings that, on the balance of probabilities, physical or sexual abuse is likely to have occurred.

#### 11.1.3.1 Suitability Panel definition of physical and sexual abuse

The CYFA does not define physical and sexual abuse and therefore, the Suitability Panel has adopted the following working definitions of physical and sexual abuse:

* **Physical abuse** means ‘non-accidental physical contact or the threat of physical contact to a child that causes or is likely to cause more than minimal or transient adverse physical or emotional consequences for the child’.
  + **Sexual abuse** means ‘sexual or indecent conduct by an adult toward a child or exposure by an adult of a child to sexual or indecent conduct’.

It is the role of the Suitability Panel to find out whether a foster or residential carer has physically or sexually abused a child, and whether they pose an unacceptable risk of harm to children and young people and should be disqualified from caring for children and young people in out-of-home care.

For further information about the Carer Register, please see the [department’s provider website](https://providers.dhhs.vic.gov.au/registration-out-home-carers) at <https://providers.dhhs.vic.gov.au/registration-out-home-carers>.

For further information about the Suitability Panel, please see the [Suitability Panel website](http://www.suitabilitypanel.vic.gov.au/) at <http://www.suitabilitypanel.vic.gov.au>.

| 11.1.4 Tips for carers |
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| If a section 81 or section 82 report about you is submitted to the department, the department will advise you that this has been received. The department will tell you whether it has decided to appoint an authorised investigator to conduct an independent investigation into the allegation of physical or sexual abuse and if so, who the investigator will be. You will be offered the opportunity to participate in the investigation by way of an interview with the investigator. You are not compelled to participate in this investigation and can opt not to be interviewed or instead, to put forward your side in writing.  However, regardless of whether you choose to participate, the investigation will continue and a decision will be made as to whether or not, on the balance of probabilities, the abuse is substantiated. Given this, you are encouraged to have your voice heard throughout the independent investigation process.  In keeping with procedural fairness, you will be given a copy of the authorised investigator’s report of their findings on the allegation made about you.  If the independent investigator substantiates the allegation of physical or sexual abuse, it is likely that the department will refer the matter to the Suitability Panel. As with the independent investigation, you will always be invited to participate in the Suitability Panel process, but you are not required to do so. You can decide what level of participation to have. You can choose to attend, not attend or to attend with a support person or legal representative.  It’s important to be aware that the Suitability Panel will hear the matter whether you choose to participate or not. This means that the Suitability Panel will make a decision about whether you should or should not be disqualified from providing out-of-home care in Victoria, regardless of your level of involvement in the proceedings. Given that the outcome of such a hearing can have serious consequences for carers, you are again strongly encouraged to take the opportunity to have your voice heard.  Whether or not you participate in the Suitability Panel hearing, you will be advised of the outcome. |

## 11.2 Commission for Children and Young People Act 2012

Two of the main purposes of the Commission for Children and Young People Act 2012 are to:

* establish a CCYP
  + provide for the functions, powers and duties of the Commission.

The CCYP has a particular interest in the safety and protection of children. It is independent of the department and service providers and one of its main objectives is to promote continuous improvement and innovation in the area of policy and practice relating to the safety and wellbeing of children and young people. It is also responsible for the Reportable Conduct Scheme and the Child Safe Standards.

### 11.2.1 Child Safe Standards

All members of the community have an obligation to do the best they can to keep children safe from harm and abuse. While for most carers it is hard to imagine anyone harming a child or young person in out-of-home care, there are occasions when this occurs. Therefore, all Victorian organisations that provide services or facilities for children are required by law to implement Child Safe Standards to protect children from harm. Children are defined in the Child Safe Standards as anyone under 18 years old.

This means that the organisations that carers are employed, approved or engaged by cannot assume that child abuse does not, and cannot, happen within their organisation and must take steps to prevent abuse. If carers would like to learn more about what an organisation is doing to comply with the Child Safe Standards and how they relate to them, they can contact their caseworker. The caseworker will be able to explain or find out how the organisation the carer is employed, approved or engaged by has implemented the standards into their practice.

For more information, please see the [CCYP website](https://ccyp.vic.gov.au/child-safety/being-a-child-safe-organisation/the-child-safe-standards/) at <https://ccyp.vic.gov.au/child-safety/being-a-child-safe-organisation/the-child-safe-standards>.

### 11.2.2 Victorian Reportable Conduct Scheme

The Victorian Reportable Conduct Scheme (the scheme) started on 1 July 2017. The CCYP is responsible for running the scheme. The scheme was introduced to make sure there was a centralised place (the CCYP) that receives all allegations of child abuse made against workers or volunteers in organisations that care for children and young people, including the organisation(s) that out-of-home carers are employed, approved or engaged by. The CCYP independently oversees responses to allegations of abuse and misconduct against workers and volunteers that care for children and young people.

The obligation to report allegations of child abuse about workers and volunteers, including carers, to the CCYP is separate to CIMS reporting and can occur in parallel.

For further information, please see the [CCYP website](file:///C:\Users\npur2607\AppData\Local\Temp\notes81ADC1\CCYP%20website) at <https://ccyp.vic.gov.au/reportable-conduct-scheme>.

# Other relevant information



## 12.1 Incidents involving Aboriginal children and young people in out-of-home care

If an incident is related to an Aboriginal child or young person in out-of-home care, the relevant ACSASS will be informed and consulted during the CIMS process.

Under the CYFA, child protection is required to consult with ACSASS regarding all significant decisions relating to an Aboriginal child. This includes the decision to change a child's placement. Child protection and service providers may also consult with a local Aboriginal community-controlled organisation to obtain advice and cultural information. Local Aboriginal community-controlled organisations are a valuable source of advice and in many circumstances will hold rich information about a child’s family, culture and community.

For more information, please see section 6 of the Out-of-home care addendum, which can be found on the [CIMS webpage](https://providers.dhhs.vic.gov.au/cims) at <https://providers.dhhs.vic.gov.au/cims>.

## 12.2 Out-of-home care client incidents involving children and young people with a disability

Where a child or young person is accessing both out-of-home care and disability support services, both child protection and the disability caseworker (where involved) must be consulted in the process of screening and investigating incidents. In these cases, the service provider responsible for the 24-hour care of the client (most likely the out-of-home care provider) takes lead responsibility for the incident screening and incident investigation process.

## 12.3 Charter for children in out-of-home care

The Charter for children and young people in out-of-home care was made for children and young people who cannot live with their parents and are in out-of-home care. It lists what they can expect from all the people who care for them and work with them. Here is the list below.

As a child or young person in care I need:

* to be safe and feel safe
* to stay healthy and well and go to a doctor, dentist or other professional for help when I need to
* to be allowed to be a child and be treated with respect
* if I am an Aboriginal child, to feel proud and strong in my own culture
* to have a say and be heard
* to be provided with information
* to tell someone if I am unhappy
* to know information about me will only be shared in order to help people look after me
* to have a worker who is there for me
* to keep in contact with my family, friends and people and places that matter to me
* careful thought being given to where I will live so I will have a home that feels like a home
* to have fun and do activities that I enjoy
* to be able to take part in family traditions and be able to learn about and be involved with cultural and religious groups that are important to me
* to be provided with the best possible education and training
* to be able to develop life skills and grow up to become the best person I can
  + help in preparing myself to leave care and support after I leave care.

| 12.3.1 Tips for carers |
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| As a carer, it is important to be familiar with this list and know that any actions you take in your caring role should be in keeping with this charter, with the intention of keeping the child or young person in your care safe and well.  If you ever feel unsure about the decisions you’ve made in your attempt to keep a child or young person in your care safe and well, contact your caseworker to talk it through so that you are not left worrying about whether the actions you’ve taken have been inconsistent with the charter. |

For more information on the Charter for children in out-of-home care, refer to the [department’s website](https://services.dhhs.vic.gov.au/charter-children-out-home-care) at <https://services.dhhs.vic.gov.au/charter-children-out-home-care>.

## 12.4 Occupational health and safety

At times, events occur that do not have a direct impact on children and young people in out-of-home care but instead impact the carers who provide out-of-home care. While CIMS only governs the management of incidents that impact clients, this does not mean that a carer’s safety and wellbeing in their role is not important. It is the responsibility of service providers to provide a safe working environment for carers. Therefore, if an event occurs that adversely affects a carer while in their caring role, they should discuss it with their caseworker or line manager within their service provider. The service provider should have its own process or policies, such as an Occupational Health and Safety policy, that will inform the response and management of the adverse event.

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| Appendix 1: Record sheet for carers |
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**Record sheet for carers**

Carers can use this record sheet to assist with keeping notes from interviews.

| Item | Notes |
| --- | --- |
| Name of carer: |  |
| Date allegation raised: |  |
| Child or young person involved: |  |
| Summary of the allegation: |  |
| My liaison person: |  |
| Liaison person’s contact number: |  |
| Interview details (time, date, venue, people present) |  |
| My notes from the interview: |  |
| Questions to ask: |  |
| Outcome of the incident investigation: |  |